Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WALTER A DEL GALLO MD
14317 N W BLVD SUITE A
CORPUS CHRISTI TX 78410

Respondent Name

TASB RISK MANAGEMENT FUND

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-4158-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not include a position summary with the DWC060.

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This request was received by the Division on July 21, 2011 which is over a year after the date of service." "The provider first submitted the original bill on 5/21/09, but didn't submit supporting documentation. Per Rule 133.210 documentation is required for the two highest Evaluation and Management office visit codes for new and established patients." "The provider resubmitted the medical bill on 11/16/09, but still with no supporting documentation. The provider never submitted a reconsideration. Per rule 133.307 (c)(2) (A) a reconsideration shall be submitted prior to filing a MDR." "As a result of the timely filing of MDR requests rule and the fact that the reconsideration submission did not follow the reconsideration rule, TASB feels the submission for MDR intervention is not viable."

Response Submitted by: TASB Risk Management Fund, 12007 Research Blvd, Austin, Texas 78759-2439

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 30, 2009	99205, 20550, J1094	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 16, 2009
   - 29 - The time limit for filing has expired.
   - 18 - Duplicate claim/service. Duplicate/Rebill of EOMB# 1814329. Previously denied for lack of supporting documentation. Still not included. Applies to all lines. Per Rule 133.20 a HCP shall not submit a medical bill later than the 95th day after the date of service for services after 09/01/05. Applies to all lines.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states in pertinent part that a request for medical fee dispute resolution shall be filed no later than one year after the date(s) of service in dispute or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. The date of service in dispute is April 30, 2009. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on July 18, 2011.
2. The Division finds no documentation to support that the dispute was filed timely. Therefore, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 13, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.